(1) Through approval of a novation agreement in accordance with the requirements of the Federal Acquisition Regulation (FAR), CMS recognizes the entity as the successor in interest to a fiscal intermediary agreement or carrier contract under which the fiscal intermediary or carrier was performing activities described in section 1893(b) of the Act on August 21, 1996.

(2) The fiscal intermediary or carrier continued to perform Medicare integrity program activities until transferring the resources to the entity.

(c) An entity is eligible to be awarded a Medicare integrity program contract only if it meets the eligibility requirements specified in §421.302; 48 CFR chapters 1 and 3; and other applicable laws and regulations.

§ 421.308 Renewal of a contract.

(a) *General.* (1) CMS specifies an initial contract term in the Medicare integrity program contract.

(2) Contracts under this subpart may contain renewal clauses.

(3) CMS may, but is not required to, renew the Medicare integrity program contract, without regard to any provision of law requiring competition, as it determines to be appropriate, by giving the contractor notice, within timeframes specified in the contract, of its intent to do so.

(b) *Conditions for renewal of contract.* CMS may renew a Medicare integrity program contract if all of the following conditions are met:

(1) The Medicare integrity program contractor continues to meet the requirements established in this subpart.

(2) The Medicare integrity program contractor meets or exceeds the performance requirements established in its current contract.

(3) It is in the best interest of the government.

(c) *Nonrenewal of a contract.* If CMS does not renew a contract, the contract ends in accordance with its terms.

§ 421.310 Conflict of interest requirements.

Offerors for MIP contracts and MIP contractors are subject to the following:

(a) The conflict of interest standards and requirements of the Federal Acquisition Regulation (FAR) organizational conflict of interest guidance specified under 48 CFR subpart 9.5.

(b) The standards and requirements as are contained in each individual contract awarded to perform section 1893 of the Act functions.

§ 421.312 Conflict of interest resolution.

(a) *Review Board.* CMS may establish and convene a Conflicts of Interest Review Board to assist the contracting officer in resolving organizational conflicts of interest.

(b) *Resolution*—(1) *Pre-award conflicts.* Resolution of an organizational conflict of interest is a determination by the contracting officer that one of the following has occurred:

(i) The conflict is mitigated.

(ii) The conflict precludes award of a contract to the offeror.

(iii) It is in the best interest of the government to award a contract to the offeror (in accordance with 48 CFR subpart 9.503) even though a conflict of interest exists.

(2) *Post-award conflicts.* Resolution of an organizational conflict of interest is a determination by the contracting officer that one of the following has occurred:

(i) The conflict is mitigated.

(ii) The conflict requires that CMS modify an existing contract.

(iii) The conflict requires that CMS terminate or not renew an existing contract.

(iv) It is in the best interest of the government to continue the contract even though a conflict of interest exists.

§ 421.316 Limitation on Medicare integrity program contractor liability.

(a) A MIP contractor, a person or an entity employed by, or having a fiduciary relationship with, or who furnishes professional services to a MIP contractor is not in violation of any criminal law or civilly liable under any law of the United States or of any State (or political subdivision thereof) by reason of the performance of any duty, function, or activity required or authorized under this subpart or under a valid contract entered into under this

subpart, provided due care was exercised in that performance and the contractor has a contract with CMS under this subpart.

(b) CMS pays a contractor, a person or an entity described in paragraph (a) of this section, or anyone who furnishes legal counsel or services to a contractor or person, a sum equal to the reasonable amount of the expenses, as determined by CMS, incurred in connection with the defense of a suit, action, or proceeding, if the following conditions are met:

(1) The suit, action, or proceeding was brought against the contractor, such person or entity by a third party and relates to the contractor's, person's or entity's performance of any duty, function, or activity under a contract entered into with CMS under this subpart.

(2) The funds are available.

(3) The expenses are otherwise allowable under the terms of the contract.

Subpart E—Medicare Administrative Contractors (MACs)

SOURCE: 71 FR 68229, Nov. 24, 2006, unless otherwise noted.

§ 421.400 Statutory basis and scope.

(a) *Statutory basis.* This subpart implements section 1874A of the Act, which provides for the transition of the claims processing functions and operations for both Medicare Part A and Part B intermediaries and carriers to Medicare Administrative Contractors (MACs). The transition will occur between October 1, 2005, and October 1, 2011. MACs will be fully operational in distinct, nonoverlapping geographic jurisdictions by October 1, 2011.

(b) *Scope.* This subpart specifies the requirements under which providers and suppliers will be assigned to MACs.

§ 421.401 Definitions.

For purposes of this subpart—

Appropriate MAC means a MAC that has a contract under section 1874A of the Act to perform a particular Medicare administrative function in relation to:

(1) A particular individual entitled to benefits under Part A or enrolled under Part B, or both;

(2) A specific provider of services or supplier; or

(3) A class of providers of services or suppliers.

Medicare Administrative Contractor (MAC) means an agency, organization, or other person with a contract under section 1874A of the Act.

§ 421.404 Assignment of providers and suppliers to MACs.

(a) *Definitions.* As used in this section—

Chain provider means a group of two or more providers under common ownership or control.

Common control exists when an individual, a group of individuals, or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of the group of suppliers or eligible providers.

Common ownership exists when an individual, a group of individuals, or an organization possesses significant equity in the group of suppliers or eligible providers.

Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) means the types of services specified in § 421.210(b).

Eligible provider means a hospital, skilled nursing facility, or critical access hospital that meets the definition of a provider under § 400.202 of this chapter.

Home office means the entity that provides centralized management and administrative services to the individual providers or suppliers under common ownership and common control, such as centralized accounting, purchasing, personnel services, management direction and control, and other similar services.

Ineligible provider means a provider under § 400.202 of this chapter that is not an eligible provider.

Medicare benefit category means a category of covered benefits under Part A or Part B of the Medicare program (for example, inpatient hospital services, post-hospital extended care services, and physicians'services).

Provider has the same meaning as specified under § 400.202 of this chapter.

Qualified chain provider means a chain provider comprised of—